LRFA

PO Box 8857
Elkins Park, PA 19027

T 215.635.4137 / info@LRFA.org
F 215.635.1583 / www.LRFA.org

This area for LRFA office use only
Effective Date:
Cert.#

TRAVEL MEDICAL PLAN APPLICATION

LRFA MEMBER'S INFORMATION

Member's Last Name | First Name | MI | LRFA Membership #

Passport Number | Family Doctor's Name & Phone Number

Member's Address

City | State | Zip Code

Phone | E-mail

Beneficiary | Relationship

COVERAGE DATES & PLAN

DESTINATION

EFFECTIVE DATE Month Day Year

RETURN DATE Month Day Year

PERIOD OF COVERAGE days

Effective date will be the latest of: 1) date of departure, 2) date requested, or 3) date application and premium are received.

Coverage automatically terminates when covered person returns to the Home Country.

PLEASE SELECT COVERAGE PLAN:

☐ **Benefit Plan A** ☐ **Benefit Plan B**

PAYMENT FOR COVERAGE DUE

Maximum period of coverage is eight (8) months

	Name	Date of Birth	Age	Nr. of Days	Payment
Covered Person					
Dependent Child					
Dependent Child					
				Total Payment:	

EXAMPLES:
For 01 to 15 day travel - 15 day rate applies
For 16 to 30 day travel - 30 day rate applies
For 31 to 45 day travel - 15 day rate + 30 day rate applies
For 46 to 60 day travel - 2 x 30 day rate applies
(***include both the departure and return dates in your total day count***)

SIGNATURE

I agree to all the terms of the LRFA Medical Travel Plan. I understand that this is not a general health insurance, and that it is intended for use in the event of a sudden and unexpected sickness or accident. I understand that pre-existing conditions are not covered.

LRFA Member's Signature | Date